1509 Film#G161 Item# 13,14 2/23/54 emf

01505

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Charles · MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Port Tobacco
LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles ·
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Port Tobacco (If rural, give location)
STREET ADDRESS

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) ELIJAH (Last) BARDROFF

4. DATE OF DEATH: (Month) 2 (Day) 16 (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	WID	2-22-1857	96 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mary C. Owens · Port Tobacco

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (Interval Between Onset and Death)

442 X

Immediate cause (a) CARDIO-VASCULAR RENAL DISEASE — 1940-54

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c) GEN ARTERIO SCLEROSIS

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1937, 19..., to ..., 1954, that I last saw the deceased alive on 2-2, 1954, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE E. J. Edelen (DEGREE OR TITLE) M.D. ADDRESS La Plata Md DATE SIGNED 2-16-54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, Town, or county) (State)
Burial	2-18-54	Mt Rest	La Plata Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/17/54	Julia H Casey	Hunt & Dyson	Waldorf Md

VS. A15 8-51

RECEIVED
FEB 19 1954
BUREAU V. S.

1516

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01506

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Spring Hill
LENGTH OF STAY (in this place): 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial, La Plata, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. — COUNTY Chas.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Spring Hill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Margaret (Middle) (Last) Day
4. DATE OF DEATH: (Month) 2 (Day) 23 (Year) 1954

5. SEX: F
6. COLOR OR RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Jan 5 1904
9. AGE last birthday: 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Charles County, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Elgie Curtis
14. MOTHER'S MAIDEN NAME: Mary Nanley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: (a) Cerebral Hemorrhage — Interval Between Onset And Death: 2 hours.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Malignant hypertension — 10 yrs.

DUE TO

(c) Diabetes Mellitus — ?

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1953, to Feb, 1954, that I last saw the deceased alive on 2/16, 1954, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Richard Day M.D. — ADDRESS: La Plata, Md. — DATE SIGNED: 2/25/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Feb. 26 1954
NAME OF CEMETERY OR CREMATORY: St. Ignatius
LOCATION (City, town, or county) (State): Bel Alton Md.

DATE REC'D BY LOCAL REGISTRAR: 2/27/54
REGISTRAR'S SIGNATURE: Julia H Casey
24. FUNERAL DIRECTOR: Hewitt & Cyon, Waldorf, Md.
ADDRESS

VS. A15

I

RECEIVED
MAR 2 1954
BUREAU V. S.

1511

MARYLAND STATE DEPARTMENT OF HEALTH

01507

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH — COUNTY: Charles — STATE: MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dentonville
   LENGTH OF STAY (in this place):
   HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Chas
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dentonville
   STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) CAWLEY (Middle) ALBERT (Last) GRIGSBY

4. DATE OF DEATH: (Month) 2 (Day) 12 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Wid

8. DATE OF BIRTH: Sept 23 1875

9. AGE last birthday: 78 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CAWLEY GRISBY

14. MOTHER'S MAIDEN NAME: Maryanth Payne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT AND ADDRESS: Howard Grigsby Washington DC.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause (a) CORONARY OCCLUSION — Interval between onset and death: 2-12-54

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Modelon (Degree or title) M.D. ADDRESS: Lusby Md. DATE SIGNED: 2-13-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 2/17/54 | NAME OF CEMETERY OR CREMATORY: Cedar Hill | LOCATION (City, town, or county) (State): Suitland Md

DATE REC'D BY LOCAL REG. 2/15/54 | REGISTRAR'S SIGNATURE: Julia H Casey | 24. FUNERAL DIRECTOR: W. W. Chambers | ADDRESS: Washington D.C.

VS. A15A

RECEIVED
FEB 16 1954
BUREAU V. S.

1512

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01837

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH: Charles County — COUNTY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Marshall Hall
LENGTH OF STAY (in this place): 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: None

2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland — STATE — COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Marshall Hall
STREET ADDRESS (If rural, give location): Route 226

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last): Elizabeth Clarkey Hackney
4. DATE OF DEATH: (Month) (Day) (Year): 2-21-54

5. SEX: F
6. COLOR OR RACE: W-US
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 12-3-1882
9. AGE last birthday: 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Goldsboro N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Rouse
14. MOTHER'S MAIDEN NAME: Rena Sanderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: (Husband) E. S. Hackney

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

420.1
Immediate cause (a) Coronary Occlusion — Immediate
DUE TO
Antecedent cause(s) (b) Arteriosclerosis — Indefinite
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c) Senility — Indefinite

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1, 1952 to 2-21, 1954 that I last saw the deceased alive on 2-21, 1954, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
James E. Andrews - Indian Head Md — 2-21-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 2-21-54
NAME OF CEMETERY OR CREMATORY: Versailles
LOCATION (City, town, or county) (State): Versailles Ky.

DATE REC'D BY LOCAL REG.: 2-21-54
REGISTRAR'S SIGNATURE: M. L. Mourer
24. FUNERAL DIRECTOR: Hunt & Ryon — ADDRESS: Waldorf Md

Mrs. Odey Price mmt

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

RECEIVED
MAR 15 1954
BUREAU V. S.

1513

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01508

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY: CHARLES — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: LA PLATA

LENGTH OF STAY (in this place): 2 DAYS.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: PHYSICIANS' MEMORIAL HOSPITAL LA PLATA, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND COUNTY: CHARLES

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: HUGHESVILLE

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month) (Day) (Year)
MARY	BLANCHE	JAMESON	FEBRUARY 3 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W-U.S.	SINGLE	NOVEMBER 18, 1895	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	MARYLAND	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Avsteamonis Jameson	Elizabeth Wheatley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO	—	/	Mrs. Irene Shultz Hughesville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
260X Immediate cause	(a) HYPERTENSIVE HEART DISEASE (ACUTE	8 YEARS
DUE TO	LEFT VENTRICULAR FAILURE)	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DIABETES MELLITUS	3 YEARS.
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒
—	—	

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
— — — M.		

22. I hereby certify that I attended the deceased from JULY, 1947, to FEB. 3, 1954, that I last saw the deceased alive on FEB. 3, 1954, and that death occurred at 6.30 P.m., from the causes and on the date stated above.

SIGNATURE: John N. Griffin, M.D. (DEGREE OR TITLE) ADDRESS: Hughesville, Md. DATE SIGNED: 2/4/54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/6/54	St. Marys Cemetery	Bryantown Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/9/54	Julia H Posey	Hoult & Ryon	Waldorf Md

RECEIVED
FEB 11 1954
BUREAU V. S.

1514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10a.

1. PLACE OF DEATH:

County: Charles

City or town: Grayton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Ironsides. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Montgomery

3.(b) Social Security Number:

4. Sex: Male 5. Color or race: Cd 6.(a) Single, married, widowed, or divorced: Widowed.

6.(b) Name of ~~husband~~ or wife: Rosie Dent Montgomery

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years: 83 Months: — Days: — If less than one day ... hrs. ... min.

9. Birthplace: Grayton, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Powder factory.

FATHER 12. Name: Martin Montgomery

13. Birthplace: Charles Co. Md.

MOTHER 14. Maiden name: Rebecca Jackson

15. Birthplace: Charles Co. Md.

16. Informant: Samuel Montgomery

Address: Grayton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1954 (month) (day) (year)

Cemetery or crematory: Mt Hope

Location: near Ironsides.

18. Funeral director: Stanley Penny

Address: Mason Springs Md

19. Feb. 12, 1954 (Date rec'd by registrar) J. W. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10th 1954 at 2 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1934 to Feb. 10 1954 and that I last saw him alive on Feb. 9 1954

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: George C. Bicknell M.D. M. D. or other

Address: Marbury Md Date signed: Feb. 10 1954

FEB
BUREAU V. S

1515

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1511

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write clearly and legibly.

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata — LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Chas
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata X
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Anthony (Middle) Madison (Last) Moschette

4. DATE OF DEATH: (Month) Feb. (Day) 8 (Year) 1954

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: Oct. 1, 1881

9. AGE last birthday: 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired-Fireman-U S Govt

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Madison Muschette

14. MOTHER'S MAIDEN NAME: Matilda Matthews

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Matilda Matthews, La Plata, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

Immediate cause (a) Cancer of Ceacum — Interval Between Onset And Death: 18 mos.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1953, to Feb. 8, 1954, that I last saw the deceased alive on Jan 14, 1953, and that death occurred at 12 noon, from the causes and on the date stated above.

SIGNATURE (Degree or title) Richard Daly M.D. — ADDRESS La Plata, Md — DATE SIGNED 2/8/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2/12/54 — NAME OF CEMETERY OR CREMATORY St Josephs Cemetery — LOCATION (City, town, or county) Pomfret (State) Md

DATE REC'D BY LOCAL REGISTRAR 2/10/54 — REGISTRAR'S SIGNATURE Julia H. Vasey

24. FUNERAL DIRECTOR Hunt & Ryon — ADDRESS Waldorf Md

VS. A15

RECEIVED
FEB 1
BUREAU V. S.

516

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel alton
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New Hampshire COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Meredith
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) R. (Last) PRICE
4. DATE OF DEATH (Month) 2 (Day) 2 (Year) 54

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M
8. DATE OF BIRTH 1-21-20
9. AGE last birthday 34 yrs. If under 1 year Months Days If under 24 Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) P.a.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ROY PRICE
14. MOTHER'S MAIDEN NAME BEATRICE ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Eldonor Price

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH 2-2-54

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) HIGHWAY 301 (CITY OR TOWN) Bel Alton (COUNTY) CHAS (STATE) MD.
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? SUDDEN DEATH WHILE DRIVING AUTO

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection ✓ Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes, accident, suicide, homicide, undetermined

SIGNATURE C. J. Edelen (Degree or title) MD. ADDRESS La Plata Md DATE SIGNED 2-2-54

FINAL CREMATION (Specify) Burial DATE THEREOF 2-3-54 NAME OF CEMETERY OR CREMATORY Washburn LOCATION (City, town, or county) Scranton (State) P.a.

DATE REC'D BY LOCAL REG 2-2-54 REGISTRAR'S SIGNATURE M. L. Monroe Julia Posey Immb. 24. FUNERAL DIRECTOR Huntt & Ryon ADDRESS Waldorf Md

MARGIN RESERVED FOR BINDING

CAST WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1513

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: La Plata
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bryantown
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last): Robey

4. DATE OF DEATH: (Month) (Day) (Year): Feb. 8, 1954

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Feb. 8, 1954

9. AGE last birthday: yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 3, Min. 16

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: George Arthur Robey

14. MOTHER'S MAIDEN NAME: Anna May Graves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: George A. Robey, Bryantown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) PREMATURITY (23 WEEK GESTATION) DUE TO	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) ATELECTASIS DUE TO	3 hrs-16 min
	(c)	

762.5

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/8, 1954, to 2/8, 1954, that I last saw the deceased alive on 2/8, 1954, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

John H. Griffin, M.D. Hughesville, Md. 2/9/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE OF — 2-9-54

NAME OF CEMETERY OR CREMATORY: St. Marys

LOCATION (City, town, or county) (State): Bryantown, Md.

DATE REC'D BY LOCAL REG. 2/9/54

REGISTRAR'S SIGNATURE: Julia H Boarman

24. FUNERAL DIRECTOR ADDRESS: Huntt & Ryon, Waldorf, Md.

RECEIVED
FEB
BUREAU V. S.

1518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Mem. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pamfret
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Egan (Middle) Michael (Last) Swann
4. DATE OF DEATH: (Month) Feb (Day) 7 (Year) 1954

5. SEX: M
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): S.
8. DATE OF BIRTH: APR- 4, 1951
9. AGE last birthday: 2 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: James Thomas Swann
14. MOTHER'S MAIDEN NAME: Catherine Geneva Swann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: James Swann, Pamfret, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 085.0
Immediate cause (a) Encephalitis — INTERVAL BETWEEN ONSET AND DEATH 1952
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Measles -
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1954, to 2-7, 1954, that I last saw the deceased alive on 2-7, 1954 and that death occurred at 10 A.M. from the causes and on the date stated above.
SIGNATURE E. J. Edelen (DEGREE OR TITLE) MD ADDRESS La Plata Md DATE SIGNED 2-8-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 2/9/54
NAME OF CEMETERY OR CREMATORY St. Joseph's
LOCATION (City, town, or county) (State) Pamfret, Md
DATE REC'D BY LOCAL REG. 2/9/54
REGISTRAR'S SIGNATURE Julia H Casey
24. FUNERAL DIRECTOR Hunt & Ryan, Waldorf, Md. ADDRESS

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BUREAU V. S.

1519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01515

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf X
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Chas.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf X
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) AUGUSTA (Middle) (Last) WASHINGTON

4. DATE OF DEATH: (Month) Feb. (Day) 13 (Year) 1954

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 1876
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Charles Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Mary Butler

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: George Washington, Waldorf, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death 2-10-54

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c) Hypertension

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-10, 1954, to 2-13, 1954, that I last saw the deceased alive on 2-10, 1954, and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE E. Redelen Md (Degree or title) ADDRESS La Plata Md DATE SIGNED 2-13-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2/17/54
NAME OF CEMETERY OR CREMATORY St. Peters Cemetery
LOCATION (City, town, or county) (State) Waldorf, Md.

DATE REC'D BY LOCAL REGISTRAR 2-17-54
REGISTRAR'S SIGNATURE M. L. Snouro
24. FUNERAL DIRECTOR Huntt & Ryon Waldorf, Md. ADDRESS

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FEB 19 1954
BUREAU V. S.

1520

01516

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ind Head
LENGTH OF STAY (in this place) 3 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head
STREET ADDRESS (If rural, give location) 9 Welsh

3. NAME OF DECEASED (Type or Print) (First) RICHARD (Middle) FRANK (Last) WHEELER
4. DATE OF DEATH (Month) 2 (Day) 9 (Year) 1954
5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 1-15-54
9. AGE last birthday yrs. If under 1 year Months Days 24 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) LA PLATA MD
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Edward Wheeler
14. MOTHER'S MAIDEN NAME Gerte L. Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Father, Ind Head Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

517X

Immediate cause (a) Suffocation 2-9-54

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Laryngeal Edema (Had lives 2-9-54) 2-9-54

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or title) MD. ADDRESS La Plata Md DATE SIGNED 2-9-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 2/10/54
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Madison, S.C.
DATE REC'D BY LOCAL REG. 2/10/54
REGISTRAR'S SIGNATURE Julia H. Pasey
24. FUNERAL DIRECTOR ADDRESS Hunt & Ryan, Waldorf, Md.

2014262449

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

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